		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011511

Facility Name: Medina Nursing Center

Address: P.O. Box 538 (Number) Durand (City) 61024 (Zip Code)

County: Winnebago

Telephone Number: (815) 248-2151 **Fax #** (815) 248-2771

IDPA ID Number: 366125769001

Date of Initial License for Current Owners: 05/18/65

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer Telephone Number: (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	89	Skilled (SNF)	89	32,485	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,485	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	148	1,657	1,805	8
9	SNF/PED					9
10	ICF	17,504	7,020		24,524	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,504	7,168	1,657	26,329	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.05%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1965

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,657

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	180,964	18,966	5,119	205,049		205,049		205,049			1
2	Food Purchase		177,350		177,350		177,350	(9,977)	167,373			2
3	Housekeeping	66,413	20,016		86,429		86,429		86,429			3
4	Laundry	63,254	11,403		74,657		74,657	(2,307)	72,350			4
5	Heat and Other Utilities			70,981	70,981		70,981		70,981			5
6	Maintenance	45,668	12,835	56,266	114,769		114,769		114,769			6
7	Other (specify):*											7
8	TOTAL General Services	356,299	240,570	132,366	729,235		729,235	(12,284)	716,951			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	806,593	28,706	232,696	1,067,995		1,067,995	2,307	1,070,302			10
10a	Therapy		991	52,918	53,909		53,909		53,909			10a
11	Activities	33,565	2,018	4,838	40,421		40,421		40,421			11
12	Social Services	50,565		1,463	52,028		52,028		52,028			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	890,723	31,715	297,915	1,220,353		1,220,353	2,307	1,222,660			16
	C. General Administration											
17	Administrative	143,286			143,286		143,286		143,286			17
18	Directors Fees											18
19	Professional Services			42,859	42,859		42,859	3,100	45,959			19
20	Dues, Fees, Subscriptions & Promotions			8,679	8,679		8,679		8,679			20
21	Clerical & General Office Expenses	51,806	12,448	11,165	75,419		75,419		75,419			21
22	Employee Benefits & Payroll Taxes			222,701	222,701		222,701		222,701			22
23	Inservice Training & Education			455	455		455		455			23
24	Travel and Seminar			5,235	5,235		5,235	(1,295)	3,940			24
25	Other Admin. Staff Transportation			4,170	4,170		4,170		4,170			25
26	Insurance-Prop.Liab.Malpractice			15,029	15,029		15,029		15,029			26
27	Other (specify):*											27
28	TOTAL General Administration	195,092	12,448	310,293	517,833		517,833	1,805	519,638			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,442,114	284,733	740,574	2,467,421		2,467,421	(8,172)	2,459,249			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Medina Nursing Center #0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			78,555	78,555		78,555	5,855	84,410			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,665	3,665		3,665	4,010	7,675			32
33	Real Estate Taxes			39,002	39,002		39,002		39,002			33
34	Rent-Facility & Grounds			36,000	36,000		36,000	(36,000)				34
35	Rent-Equipment & Vehicles			17,916	17,916		17,916		17,916			35
36	Other (specify):*											36
37	TOTAL Ownership			175,138	175,138		175,138	(26,135)	149,003			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		33,428	2,110	35,538		35,538		35,538			39
40	Barber and Beauty Shops	9,714	285		9,999		9,999		9,999			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,727	48,727		48,727		48,727			42
43	Other (specify):* Nonallowable costs			33,559	33,559		33,559	(33,559)				43
44	TOTAL Special Cost Centers	9,714	33,713	84,396	127,823		127,823	(33,559)	94,264			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,451,828	318,446	1,000,108	2,770,382		2,770,382	(67,866)	2,702,516			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

**See schedule of adjustments attached at end of cost report

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,977)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(14,159)	30		9
10	Interest and Other Investment Income	(1,379)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,535)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,810)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,431)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule 5A	(24,078)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (60,369)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(7,497)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (7,497)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (67,866)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center, Inc.
Provider # 0011551
December 31, 2001

Page 5 **Schedule 5A**

Schedule VI.- Adjustment Detail
Line 29, Other Non-Allowable Expenses

Description	**Amount**	**Sch V line reference**
Vending Machine Supply	(6,671)	43
Laboratory Expense	(14,042)	43
Insurance	(2,070)	43
Out of State Travel	(1,295)	24
	(24,078)	

See Accountants' Compilation Report

Medina Nursing Center

ID# 0011511

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Medina Nursing Center # 0011511 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,977)	0	0	0	0	0	0	0	0	0	0	(9,977)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,977)	0	0	0	0	0	0	0	0	0	0	(9,977)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,100	0	0	0	0	0	0	0	0	0	3,100	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	3,100	0	0	0	0	0	0	0	0	0	3,100	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,977)	3,100	0	0	0	0	0	0	0	0	0	(6,877)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Medina Nursing Center **#** 0011511 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(14,159)	20,014	0	0	0	0	0	0	0	0	0	5,855	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,379)	5,389	0	0	0	0	0	0	0	0	0	4,010	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(36,000)	0	0	0	0	0	0	0	0	0	(36,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(15,538)	(10,597)	0	0	0	0	0	0	0	0	0	(26,135)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(10,776)	0	0	0	0	0	0	0	0	0	0	(10,776)	43
44	**TOTAL Special Cost Centers**	(10,776)	0	0	0	0	0	0	0	0	0	0	(10,776)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(36,291)	(7,497)	0	0	0	0	0	0	0	0	0	(43,788)	45

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Holgeir J. Oksnevad	100%			Medina Manor Building, Inc.	Durand	Lessor
				- Owner Johs Oksnevad is the father of Holgeir Oksnevad.		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Accounting Fees	$	Medina Manor Building, Inc.	0.00%	$ 3,100	$ 3,100	1
2	V	30	Depreciation		Medina Manor Building, Inc.	0.00%	20,014	20,014	2
3	V	32	Interest		Medina Manor Building, Inc.	0.00%	5,389	5,389	3
4	V	34	Rent Income	36,000	Medina Manor Building, Inc.	0.00%		(36,000)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 36,000			$ 28,503	$ * (7,497)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Holgeir Oksnevad	President	Administrator	100.00	None	55	100.00	Salary	$ 143,286	L17, C1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 143,286		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10					N/A					10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	State Bank of Davis		X	Bus Loan	$816.00	06/15/98	$ 40,200	$ 13,779	06/15/03	0.0825	$ 1,511	1
2	State Bank of Davis		X	Auto Loan	$781.00	02/26/99	25,020	1,552	02/26/02	0.0775	497	2
3	State Bank of Davis		X	Auto Loan	$919.00	07/25/00	22,065	6,219	07/25/02	0.0925	1,110	3
4												4
5												5
	Working Capital											
6	Unsecured notes allocated from	X		Working Capital	None	Various	Various	42,860	Demand	0.0700	5,389	6
7	Medina Manor Building											7
8												8
9	TOTAL Facility Related				$2,516.00		$ 87,285	$ 64,410			$ 8,507	9
	B. Non-Facility Related*											
10									Interest Income Offset		(1,379)	10
11									Miscellaneous Interest Exp		547	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (832)	14
15	TOTALS (line 9+line14)						$ 87,285	$ 64,410			$ 7,675	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 33,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 35,002	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,002	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 37,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 39,002	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:						
1996	31,170	8	2000 Estimated Tax	35,002		**FOR OHF USE ONLY**
1997	33,224	9	Estimated Tax Increase	1.05		
1998	32,672	10		36,750	13	FROM R. E. TAX STATEMENT FOR 2000 $ 13
1999	31,868	11	use	37,000		
2000	35,002	12			14	PLUS APPEAL COST FROM LINE 5 $ 14
					15	LESS REFUND FROM LINE 6 $ 15
					16	AMOUNT TO USE FOR RATE CALCULATION $ 16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Medina Nursing Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0011511

CONTACT PERSON REGARDING THIS REPORT Charles J. Fischer

TELEPHONE (312) 634-4580 FAX #: (312) 634-5518

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-15-251-001 to 003	Medina Manor Buildings	$ 35,002.00	$ 35,002.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,002.00	$ 35,002.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,000 B. General Construction Type: Exterior Brick Frame Masonry, Fire Resist Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Medina Manor Apartments
-Retirement Apartments
-22 units
-20,000 Sq. ft

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	7 acres	1965	$ 3,048	1
2					2
3	TOTALS	7 acres		$ 3,048	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1965	1965	$ 488,644	$	30	$	$	$ 488,644	4
5	25		1980	1980	158,172		30	5,272	5,272	116,145	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1968	675		15			675	9
10	Building Improvements			1974	861		10			861	10
11	Building Improvements			1975	1,547		10			1,547	11
12	Building Improvements			1976	345		9			345	12
13	Building Improvements			1977	12,614		21			12,614	13
14	Building Improvements			1977	2,793		8			2,793	14
15	Building Improvements			1979	2,620		7			2,620	15
16	Building Improvements			1980	24,465		20			24,465	16
17	Building Improvements			1980	2,137		7			2,137	17
18	Building Improvements			1981	20,211		15			20,211	18
19	Building Improvements			1982	2,305		20	115	115	2,305	19
20	Building Improvements			1983	705		5			705	20
21	Building Improvements			1985	980		10			980	21
22	Building Improvements			1985	3,091	103	20	155	52	2,554	22
23	Building Improvements			1986	17,543		10			17,543	23
24	Building Improvements			1987	56,373	1,879	20	2,819	940	40,866	24
25	Building Improvements			1988	14,212	947	20	711	(236)	9,591	25
26	Building Improvements			1989	30,063	2,004	20	1,503	(501)	18,789	26
27	Building Improvements			1990	1,601	107	20	80	(27)	924	27
28	Building Improvements			1991	51,619	3,441	20	2,581	(860)	27,100	28
29	Building Improvements			1991	11,626		20	581	581	5,522	29
30	Building Improvements			1992	39,070	2,605	20	1,954	(651)	16,607	30
31	Building Improvements			1992	3,295	203	20	165	(38)	1,565	31
32	Building Improvements			1992	19,372		20	969	969	9,203	32
33	Building Improvements			1992	23,809	2,362	20	1,190	(1,172)	11,305	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvements	1993	$ 37,059	$ 2,471	20	$ 1,853	$ (618)	$ 15,751	37
38	Building Improvements	1993	100,000		20	5,000	5,000	41,667	38
39	Building Improvements	1994	53,900	3,216	20	2,695	(521)	20,212	39
40	Building Improvements	1994	15,610		10	1,561	1,561	11,707	40
41	Building Improvements	1995	47,826	3,188	15	3,188		20,723	41
42	Building Improvements	1995	36,144	2,410	15	2,410		15,664	42
43	Outdoor Signs	1996	2,149	143	15	143		787	43
44	Backflow Preventors	1996	3,679	245	15	245		1,348	44
45	Garbage Disposal	1996	761	51	15	51		280	45
46	Custom Therapy Cabinets	1997	2,532	169	15	169		760	46
47	Door	1997	1,996	133	15	133		599	47
48	Sign	1997	666	44	15	44		199	48
49	Air Conditioner	1997	3,500	233	15	233		1,049	49
50	Lights	1997	621	41	15	41		185	50
51	Driveway	1997	2,875	192	15	192		864	51
52	Fire Alarm	1997	1,246	83	15	83		374	52
53	Plumbing	1997	5,122	341	15	341		1,535	53
54	Telephone System	1997	1,152	77	15	77		322	54
55	Permanent Outdoor Receptacles	1997	585	39	15	39		176	55
56	Office Remodeling	1998	2,454	164	15	164		574	56
57	Exterior Doors	1998	7,652	510	15	510		1,785	57
58	Windows	1998	15,536	1,036	15	1,036		3,626	58
59	Roof Repair	1998	2,317	154	15	154		539	59
60	Water and Sewer Improvements	1998	3,165	211	15	211		737	60
61	Fire Alarm	1998	1,157	77	15	77		270	61
62	Telephone System	1998	1,467	98	15	98		341	62
63	Time Clock System	1998	8,238	549	15	549		1,923	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,350,157	$ 29,526		$ 39,392	$ 9,866	$ 982,613	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,350,157	$ 29,526		$ 39,392	$ 9,866	$ 982,613	1
2	Blinds	1999	3,689	246	15	246		613	2
3	Window Replacement	1999	5,145	305	15	343	38	858	3
4	Rewire & Replumb Laundry Room	1999	7,824	481	15	521	40	1,303	4
5	Floor Tile	1999	1,049	70	15	70		175	5
6	Air Conditioning	1999	1,895	126	15	126		315	6
7	Boiler	1999	535	35	15	35		88	7
8	Sidewalk	2000	1,386	92	15	92		138	8
9	Kickplates	2000	608	40	15	40		60	9
10	Landscaping Brick	2000	1,139	76	15	76		114	10
11	Blacktop Parking Lot	2001	15,000	500	15	500		500	11
12	Dumpster Gate Frames	2001	1,650	55	15	55		55	12
13	Dumpster Concrete Platform	2001	3,700	123	15	123		123	13
14	Stone Wall	2001	1,665	55	15	55		55	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,395,442	$ 31,730		$ 41,674	$ 9,944	$ 987,010	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 179,366	$ 22,775	$ 18,685	$ (4,090)	10 Years	$ 107,013	71
72	Current Year Purchases	2,986	263	263		10 Years	263	72
73	Fully Depreciated Assets	12,502					12,502	73
74								74
75	TOTALS	$ 194,854	$ 23,038	$ 18,948	$ (4,090)		$ 119,778	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Activity Bus	1975 Ford Bus	1985	$ 9,409	$	$	$	3	$ 9,409	76
77	Resident Van	1991 Chevy Lumina	1991	18,008				3	18,008	77
78	Activity Bus	1998 Ford Bus	1998	49,705	9,941	9,941		5	44,734	78
79	From Page 13A			69,220	13,846	13,847	1	5	48,075	79
80	TOTALS			$ 146,342	$ 23,787	$ 23,788	$ 1		$ 120,226	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,739,686	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 78,555	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 84,410	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,855	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,227,014	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$ 0		$	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	$ 0	$ 0	$ 0	$ 0		$ 0	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administrative	1999 Lexus SUV	1998	$ 45,515	$ 9,103	$ 9,104	$ 1	5	40,963	76
77	Maintenance	1997 Dodge Pickup	2000	23,705	4,743	4,743	0	5	7,112	77
78							0			78
79							0			79
80	TOTALS			$ 69,220	$ 13,846	$ 13,847	$ 1		$ 48,075	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	1998 BMW	$ 1,290.51	$ 2,581	17
18	Administrative	2000 BMW	984.97	15,335	18
19					19
20					20
21	TOTAL		$ 2,275.48	$ 17,916	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or)	Total Units	Total Cost	
			Units of Service	Cost	Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C3	hrs	$	713	$ 21,977	$	713	$ 21,977	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		63	1,899		63	1,899	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C2&3	hrs		593	29,042	991	593	30,033	4
5	Physician Care		visits							5
6	Dental Care	L39, C3	visits				2,110		2,110	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				33,428		33,428	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	1,369	$ 52,918	$ 36,529	1,369	$ 89,447	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Medina Nursing Center # 0011511 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 95,747	$ 95,747	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	384,985	384,985	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,092	33,092	6
7	Other Prepaid Expenses	42,153	43,387	7
8	Accounts Receivable (owners or related parties)	7,230	7,230	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 563,207	$ 564,441	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,048	13
14	Buildings, at Historical Cost		646,814	14
15	Leasehold Improvements, at Historical Cost	538,510	748,628	15
16	Equipment, at Historical Cost	574,122	341,196	16
17	Accumulated Depreciation (book methods)	(769,909)	(1,227,014)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Life Insurance Cash Value	39,290	39,290	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 382,013	$ 551,962	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 945,220	$ 1,116,403	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 10,826	$ 10,826	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	115,330	115,076	28
29	Short-Term Notes Payable		42,860	29
30	Accrued Salaries Payable	73,669	73,669	30
31	Accrued Taxes Payable (excluding real estate taxes)	36,353	36,353	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,000	37,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	19,376	19,376	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 292,554	$ 335,160	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	21,550	21,550	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 21,550	$ 21,550	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 314,104	$ 356,710	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 631,116	$ 759,693	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 945,220	$ 1,116,403	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Medina Nursing Center, Inc.
Provider # 0011551
December 31, 2001

Page 17 **Schedule 17A**
Schedule XV.
Balance Sheet

Line 36- Other Current Liabilities

	Column 1 Operating	Column 2 After Consolidation
Miscellaneous Current Liabilities	1,281	1,281
Due to Related Party	3,095	3,095
Due to Apartments	15,000	15,000
Total	19,376	19,376

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 553,287	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 553,287	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	127,823	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 77,823	17
	B. Transfers (Itemize):		
18	**Rounding Adjustment**	6	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 6	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 631,116	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,553,442	1
2	Discounts and Allowances for all Levels	108,380	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,661,822	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	90,413	6
7	Oxygen	2,751	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 93,164	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,563	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	38,347	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,550	19
20	Radiology and X-Ray		20
21	Other Medical Services	69,769	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 120,229	23
	D. Non-Operating Revenue		
24	Contributions	40	24
25	Interest and Other Investment Income***	1,379	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,419	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Schedule 19A	21,571	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,571	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,898,205	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	729,235	31
32	Health Care	1,220,353	32
33	General Administration	517,833	33
	B. Capital Expense		
34	Ownership	175,138	34
	C. Ancillary Expense		
35	Special Cost Centers	79,096	35
36	Provider Participation Fee	48,727	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,770,382	40
41	**Income before Income Taxes (line 30 minus line 40)****	127,823	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 127,823	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Medina Nursing Center, Inc.
Provider # 0011551
December 31,2001

Page 19 **Schedule 19A**
Schedule XVII
Income Statement

Line 28a-Other Revenue (specify):

	Amount
Vending Machine Income	**8,697**
Uniform Income	**2,566**
Food Purchased	**4,173**
Meal Sales	**5,804**
Miscellaneous Income	**331**
Total	**21,571**

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,040	2,080	$ 44,584	$ 21.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,652	8,070	157,249	19.49	3
4	Licensed Practical Nurses	7,439	7,809	127,586	16.34	4
5	Nurse Aides & Orderlies	42,447	44,617	410,186	9.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,806	1,960	18,363	9.37	9
10	Activity Assistants	2,042	2,163	15,202	7.03	10
11	Social Service Workers	3,855	4,135	50,565	12.23	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	25,960	12.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,272	21,506	155,004	7.21	15
16	Dishwashers					16
17	Maintenance Workers	5,218	5,381	45,668	8.49	17
18	Housekeepers	7,171	7,714	66,413	8.61	18
19	Laundry	7,663	8,218	63,254	7.70	19
20	Administrator	2,700	2,860	143,286	50.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,009	4,328	51,806	11.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,040	2,230	21,999	9.87	31
32	Other Health Ca Care Plan Coordin	2,088	2,273	44,989	19.79	32
33	Other(specify) Barber & Beauty	1,026	1,105	9,714	8.79	33
34	TOTAL (lines 1 - 33)	121,428	128,529	$ 1,451,828 *	$ 11.30	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	106	$ 5,119	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	812	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	24	1,463	L12, C3	45
46	Other(specify) Speech Rehab Consult	11	920	L10, C3	46
47	Physical Rehab Consulting	213	1,163	L10, C3	47
48	Occupational Rehab Consulting	226	1,390	L10, C3	48
49	TOTAL (lines 35 - 48)	580	$ 16,867		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	546	$ 19,070	L10, C3	50
51	Licensed Practical Nurses	283	9,240	L10, C3	51
52	Nurse Aides	10,262	200,101	L10, C3	52
53	TOTAL (lines 50 - 52)	11,091	$ 228,411		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Holgeir Oksnevad	Administrator	100%	$ 143,286
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 143,286

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser LLP	Accounting	$ 17,350
American Express Tax &		
Business Services	Accounting	4,285
Duane, Morris, & Heckscher	Legal	1,112
Achieve Software	Computer	14,134
Mutual of Omaha	Computer	227
Aero Internet Service	Computer	215
Information Control	Computer	1,130
Business Management	Computer	3,210
First USA Bank (Comp USA)	Computer	1,196
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 42,859

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,103
Unemployment Compensation Insurance	8,713
FICA Taxes	105,169
Employee Health Insurance	48,145
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical	2,487
401(k) Plan	7,784
Employee Education	2,571
Employee Goodwill	6,128
Uniforms	2,602
TOTAL (agree to Schedule V, line 22, col.8)	$ 222,701

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 100
Advertising: Employee Recruitment	1,172
Health Care Worker Background Check	
(Indicate # of checks performed 36)	432
Illinois Health Care Association	4,971
Vehicle License	617
Subscriptions & Publications	1,387
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,679

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,940
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,940

* Attach copy of IMRF notifications

**See instructions.

Facility Name	**Medina Nursing Center**
PROVIDER #	**0011511**
Period Ending	**12/31/01**

Schedule 21C

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	42,859
Allocated from Related Party	3,100
Total (agree to Schedule V, line 19, column 8)	45,959

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011511 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $ 4,971**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,307** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **48,727**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **9,977**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	180,964	18,966	5,119	205,049	0	205,049	0	205,049
2. Food Purcha	0	177,350	0	177,350	0	177,350	-9,977	167,373
3. Housekeepi	66,413	20,016	0	86,429	0	86,429	0	86,429
4. Laundry	63,254	11,403	0	74,657	0	74,657	-2,307	72,350
5. Heat and Ot	0	0	70,981	70,981	0	70,981	0	70,981
6. Maintenanc	45,668	12,835	56,266	114,769	0	114,769	0	114,769
7. Other (spec	0	0	0	0	0	0	0	0
8. Total Gener	356,299	240,570	132,366	729,235	0	729,235	-12,284	716,951
9. Medical Dire	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursing &	806,593	28,706	232,696	1,067,995	0	1,067,995	2,307	1,070,302
10a. Therapy	0	991	52,918	53,909	0	53,909	0	53,909
11. Activities	33,565	2,018	4,838	40,421	0	40,421	0	40,421
12. Social Ser	50,565	0	1,463	52,028	0	52,028	0	52,028
13. Nurse Aide	0	0	0	0	0	0	0	0
14. Program T	0	0	0	0	0	0	0	0
15. Other (spe	0	0	0	0	0	0	0	0
16. Total Healt	890,723	31,715	297,915	1,220,353	0	1,220,353	2,307	1,222,660
17. Administra	143,286	0	0	143,286	0	143,286	0	143,286
18. Directors F	0	0	0	0	0	0	0	0
19. Profession	0	0	42,859	42,859	0	42,859	3,100	45,959
20. Fees, Subs	0	0	8,679	8,679	0	8,679	0	8,679
21. Clerical & (	51,806	12,448	11,165	75,419	0	75,419	0	75,419
22. Employee	0	0	222,701	222,701	0	222,701	0	222,701
23. Inservice T	0	0	455	455	0	455	0	455
24. Travel and	0	0	5,235	5,235	0	5,235	-1,295	3,940
25. Other Adm	0	0	4,170	4,170	0	4,170	0	4,170
26. Insurance-	0	0	15,029	15,029	0	15,029	0	15,029
27. Other (spe	0	0	0	0	0	0	0	0
28. Total Gene	195,092	12,448	310,293	517,833	0	517,833	1,805	519,638
29. Total Gene	1,442,114	284,733	740,574	2,467,421	0	2,467,421	-8,172	2,459,249
30. Depreciatic	0	0	78,555	78,555	0	78,555	5,855	84,410
31. Amortizatic	0	0	0	0	0	0	0	0
32. Interest	0	0	3,665	3,665	0	3,665	4,010	7,675
33. Real Estat	0	0	39,002	39,002	0	39,002	0	39,002
34. Rent - Fac	0	0	36,000	36,000	0	36,000	-36,000	0
35. Rent - Equ	0	0	17,916	17,916	0	17,916	0	17,916
36. Other (spe	0	0	0	0	0	0	0	0
37. Total Owne	0	0	175,138	175,138	0	175,138	-26,135	149,003
38. Medically I	0	0	0	0	0	0	0	0
39. Ancillary S	0	33,428	2,110	35,538	0	35,538	0	35,538
40. Barber and	9,714	285	0	9,999	0	9,999	0	9,999
41. Coffee and	0	0	0	0	0	0	0	0
42. Provider P	0	0	48,727	48,727	0	48,727	0	48,727
43. Other (spe	0	0	33,559	33,559	0	33,559	-33,559	0
44. Total Spec	9,714	33,713	84,396	127,823	0	127,823	-33,559	94,264
45. Grand Tota	1,451,828	318,446	1,000,108	2,770,382	0	2,770,382	-67,866	2,702,516

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	95,747	95,747
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	384,985	384,985
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	33,092	33,092
7. Other Prepaid Expenses	42,153	43,387
8. Accounts Receivable-Owner/Related Party	7,230	7,230
9. Other (specify):	0	0
10. Total current assets	563,206	564,440
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	3,048
14. Buildings, at Historical Cost	0	646,814
15. Leasehold Improvements, Historical Cost	538,510	748,628
16. Equipment, at Historical Cost	574,122	341,196
17. Accumulated Depreciation (book methods)	-769,909	-1,227,014
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	39,290	39,290
24. Total Long-Term Assets	382,013	551,962
25. Total Assets	945,219	1,116,402
CURRENT LIABILITIES		
26. Accounts Payable	10,826	10,826
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	115,330	115,076
29. Short-Term Notes Payable	0	42,860
30. Accrued Salaries Payable	73,669	73,669
31. Accrued Taxes Payable	36,353	36,353
32. Accrued Real Estate Taxes	37,000	37,000
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	19,376	19,376
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	292,554	335,160
LONG TERM LIABILITES		
39.Long-Term Notes Payable	21,550	21,550
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	21,550	21,550
46.Total Liabilities	314,104	356,710
47.Total Equity	631,115	759,692
48.Total Liabilities and Equity	945,219	1,116,402

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,553,442
2. Discounts and Allowances for all Levels	108,380
Subtotal - Inpatient Care	2,661,822
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	90,413
7. Oxygen	2,751
Subtotal - Anciliary Revenue	93,164
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0.00
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	6,563
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	38,347
18. Sale of Supplies to Non-Patients	0
19. Laboratory	5,550
20. Radiologyand X-Ray	0
21. Other Medical Services	69,769
22. Laundry	0
Subtotal - Other Operating Revenue	120,229
24. Contributions	40
25. Interest and Other Investments Income	1,379
Subtotal - Non-Operating Revenue	1,419
27. Other Revenue (specify):	0
28. Other Revenue (specify):	21,571
Subtotal - Other Revenue	21,571
30. Total Revenue	2,898,205
31. General Services	729,235
32. Health Care	1,220,353
33. General Administration	517,833
34. Ownership	175,138
35. Special Cost Centers	79,096
35. Provider Participation Fee	48,727
37. Other	0
40. Total Expenses	2,770,382
41. Income Before Income Taxes	127,823
42. Income Taxes	0
43. Net Income or Loss for the Year	127,823

Page

Attachment of Real Estate Bill and fill out form

P12 does not show totals, it carries to P12a, therefore P12a must always be attached

The bottom right side of page under **, you must write in any comments

RECONCILIATION REPORT **Medina Nursing Center** **03:31 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CELL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-67,866	equal to	-67,866	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	7,675	equal to	7,675	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	39,002	equal to	39,002	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	84,410	equal to	84,410	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	17,916	equal to	17,916	0	FAILED	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	53,909	equal to	53,909	0	O.K.	Pg16 Z12+Z14..Z16 & Pg 20 X17..X20	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	36,529	equal to	34,419	2,110	FAILED	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	729,235	equal to	729,235	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,220,353	equal to	1,220,353	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	517,833	equal to	517,833	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	175,138	equal to	175,138	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	79,096	equal to	79,096	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	48,727	equal to	48,727	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	761,604	equal to	806,593	-44,989	FAILED	Pg20 K11..K15+K35+K36+K38..K44	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	33,565	equal to	33,565	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	50,565	equal to	50,565	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	180,964	equal to	180,964	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	45,668	equal to	45,668	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	66,413	equal to	66,413	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	63,254	equal to	63,254	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	143,286	equal to	143,286	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	51,806	equal to	51,806	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,451,828	equal to	1,451,828	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	5,119	< or = to	5,119	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	229,223	< or = to	232,696	-3,473	O.K.	Pg20 X14..X16+X37..X39	B. & C.	ȝ7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	4,838	-4,838	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,463	< or = to	1,463	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	143,286	equal to	143,286	0	FAILED	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	42,859	equal to	42,859	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	222,701	equal to	222,701	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	8,679	equal to	8,679	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	3,940	equal to	3,940	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	48,727	equal to	48,727	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,657	equal to	1,657	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-7,497	equal to	-7,497	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	64,410	equal to	64,410	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	37,000	equal to	37,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	3,048	equal to	3,048	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,395,442	equal to	1,395,442	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	341,196	equal to	341,196	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,227,014	equal to	1,227,014	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	631,116	equal to	631,116	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	127,823	equal to	127,823	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S31	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	945,220	equal to	945,220	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1